MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08035 **CERTIFICATE OF DEATH** 08030

Reg. Dist. No. 3-3

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishopville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: xxx

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 Bishopville
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Helen — Middle R. — Last Bishop

4. DATE OF DEATH: Month July — Day 5 — Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb 16, 1885

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Bishop

14. MOTHER'S MAIDEN NAME: Carrie King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): X (If yes, give war or dates of service): X

16. SOCIAL SECURITY NO.: xxx

17. INFORMANT — Address: Miss Lizzie Bishop Bishopville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction due to — INTERVAL BETWEEN ONSET AND DEATH: 5-10 minutes

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): coronary thrombosis (or ventricular fibrillation) —

DUE TO (c): Arterio sclerotic heart disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cardiovascular instability

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1955 to 2 July, 1957, that I last saw the deceased alive on 2 July 1957, and that death occurred at 10:?? M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl B. McFadden, M.D. — ADDRESS (Street, city or town, state): Selbyville, Del. — DATE SIGNED

PHYSICIAN'S NAME (Type): Earl B. McFADDEN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/8/57

22c. NAME OF CEMETERY OR CREMATORY: I O O F

22d. LOCATION (City, town, or county) (State): Bishopville Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Peter Wholey Selbyville Del.

24a. REC'D BY REGISTRAR — DATE: JUL 10 1957

24b. REGISTRAR'S SIGNATURE: Hilda H. Bergey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08031 (typed) 08031 (written) Reg. Dist. No. 350

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Front Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 42 Pocomoke City
d. STREET ADDRESS: 1 Front Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First H. Middle Clarke Last Bratten
4. DATE OF DEATH: Month July Day 25 Year 1957
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: January 18, 1887
9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Meat Cutter
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William F. Bratten
14. MOTHER'S MAIDEN NAME: Minnie P. Stevenson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: J.C. Stevenson, Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Protracted Asthmatic attacks
241X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): General Weakness after Surgery on June 5)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: N. E. Sartorius M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): N. E. Sartorius Sr.
DATE SIGNED: 7/26/57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-27-57
22c. NAME OF CEMETERY OR CREMATORY: Salem M.E. Cemetery
22d. LOCATION (City, town, or county) (State): Pocomoke City, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Henry A. Watson ADDRESS: Pocomoke, Md.
24a. REC'D BY REGISTRAR DATE: JUL 29 1957
24b. REGISTRAR'S SIGNATURE: Anne White

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08036 — 08032 353 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near St. Martins
c. LENGTH OF STAY IN 1b: Accident
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): XXXXX

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x/ Whaleyville
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Richard — Middle Alton — Last Cathell
4. DATE OF DEATH: Month July — Day 26 — Year 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 18, 1939
9. AGE (In years last birthday): 17 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Ice Plant
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Cathell
14. MOTHER'S MAIDEN NAME: Christeen Holland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): XX (If yes, give war or dates of service): XX
16. SOCIAL SECURITY NO.: 215-36-0689
17. INFORMANT — Address: Chas. Cathell Whaleyville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fracture of Skull, Cont & Compression of — INTERVAL BETWEEN ONSET AND DEATH: 5 to 10 min
816x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Acute Pulmonary Edema
DUE TO (c): accident

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): accident ran into back of truck
20c. TIME OF INJURY: 7 Hour a.m. p.m. — Month, Day, Year: 7/26 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): U.S Hwy. #50
20f. (City or town) St. Martin — (County) Worcester — (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Herman A. Robbins M.D. — CHIEF MEDICAL EXAMINER ☐ — ASSISTANT MEDICAL EXAMINER ☐ — DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: 7/26/57
EXAMINER'S NAME (Type): HERMAN A. ROBBINS

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/29/57
22c. NAME OF CEMETERY OR CREMATORY: I O O F
22d. LOCATION (City, town, or county) (State): Bishopville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Peter Whaley Selbyville Del
24a. REC'D BY REGISTRAR — DATE: JUL 30 1957
24b. REGISTRAR'S SIGNATURE: Hilda R. Bryan

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C8932 **CERTIFICATE OF DEATH** Reg. Dist. No. 08033 350

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 714 5th. Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City 42
d. STREET ADDRESS: 714 5th
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First John Middle Sidney Last Collins
4. DATE OF DEATH: Month July Day 18 Year 1957

5. SEX: M.
6. COLOR OR RACE: C.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 27 188[illegible]
9. AGE (In years last birthday): 68 ~~74~~ yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clergymen
10b. KIND OF BUSINESS OR INDUSTRY: Minister
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: UU.S.A.

13. FATHER'S NAME: James Collins
14. MOTHER'S MAIDEN NAME: Sarah Ellen Gale

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Estella Collins, Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Pulmonary Edema	1 hr
DUE TO (b)	Congestive Heart Failure	2 1/2 yr.
DUE TO (c)	Hypertensive Heart Disease	3 yr.

443X

Conditions, if ony, which gave rise to Immediate cause (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

434.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7-13-, 1957, to 7-18-, 1957, that I last saw the deceased alive on 7/18, 1957, and that death occurred at 11:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Cecil A. Downey M.D. ADDRESS (Street, city or town, state): 201 4th St, Pocomoke, Md. DATE SIGNED: 7/22/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/22/57
22c. NAME OF CEMETERY OR CREMATORY: Halls Hill Cem.
22d. LOCATION (City, town, or county) (State): Pocomoke City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton ADDRESS: New Church, Va.
24a. REC'D BY REGISTRAR DATE: JUL 26 1957
24b. REGISTRAR'S SIGNATURE: Anne White

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

1

Item 20 Film 218 8-7-57 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C8037

08034 353
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Near St Martins
c. LENGTH OF STAY IN 1b: Accident

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Whaleyville, Md.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): XXXXX
d. STREET ADDRESS: / RFD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Harry Middle W. Last Davis
4. DATE OF DEATH: Month July Day 26 Year 1957
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: April 6, 1881
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ephram Davis
14. MOTHER'S MAIDEN NAME: Jane (Unknown)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): XXX (If yes, give war or dates of service): XXX
16. SOCIAL SECURITY NO.: 215-26-5075
17. INFORMANT: Annie Davis Address: Whaleyville, Md. RFD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shock due to Fracture Skull, Fracture Mandible — Instantly
825X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Hemorrhage, Lacerations
DUE TO (c): Wound of Head, Crushed Chest

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
—

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): accident - Automobile
20c. TIME OF INJURY: Hour 7 p. m. Month, Day, Year 7/26 1957
20d. INJURY OCCURRED: While at work [ ] Not while at work [X]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): U.S. Hyway #50
20f. (City or town) St. Martins (County) Worcester (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and find that death resulted from: Natural causes [ ], Accident [X] Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: Herman A. Robbins M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
EXAMINER'S NAME (Type): HERMAN A. ROBBINS M.D.
DATE SIGNED: 7/26/57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 7/28/57
22c. NAME OF CEMETERY OR CREMATORY: Pulletts Chapel
22d. LOCATION (City, town, or county) (State): Whaleyville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley Lellyville Md. ADDRESS
24a. REC'D BY REGISTRAR DATE: JUL 30 1957
24b. REGISTRAR'S SIGNATURE: Hilda R. Bergey

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08038

CERTIFICATE OF DEATH

08035 251

Reg. Dist. No.

1

M

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
c. LENGTH OF STAY IN 1b: 57 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mary Middle: E. Last: Davis

4. DATE OF DEATH: Month: July Day: 8 Year: 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jul 22 - 1876

9. AGE (In years last birthday): 81 4/12 Yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Berlin, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Gaylord L. Warren

14. MOTHER'S MAIDEN NAME: Ellen Cropper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Address: Mr. Wm E. Davis, Newark, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertensive Cardiovascular Disease — 3
DUE TO
(c):

443 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

434.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9/15/55 to 7/8/57, that I last saw the deceased alive on 7/8/57, and that death occurred at 1:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas L. Jones, MD — ADDRESS (Street, city or town, state): 512 E. Market St. Snow Hill, Md — DATE SIGNED: 7/8/57

PHYSICIAN'S NAME (Type): Thomas L. Jones, MD

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 10/57

22c. NAME OF CEMETERY OR CREMATORY: Bowen Cemetery

22d. LOCATION (City, town, or county) (State): Newark Md

23. FUNERAL DIRECTOR'S SIGNATURE: Elliott & Timmons — ADDRESS: Snow Hill, Md

24a. REC'D BY REGISTRAR DATE: JUL 10 1957

24b. REGISTRAR'S SIGNATURE: Elwyn Coopers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08039 **CERTIFICATE OF DEATH** 08036 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X) BERLIN
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First DORA Middle FLORENCE Last DENNIS

4. DATE OF DEATH: Month JULY Day 16 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: OCT. 27, 1885

9. AGE (In years last birthday): 71 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): BERLIN MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN SMACK

14. MOTHER'S MAIDEN NAME: ELIZABETH KELLEX

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NO

17. INFORMANT: MR. WALTER DENNIS Address: BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Static pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Cerebral vascular accident — 2 mos.
DUE TO
(c): Hypertension — 10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 260 Atherosclerosis and Diabetes Melitus

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1953, to July, 1957, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A. Grubb M.D. ADDRESS (Street, city or town, state): BERLIN, MD. DATE SIGNED: 7-16-57

PHYSICIAN'S NAME (Type): ROBERT A. GRUBB

22a. BURIAL, CREMATION, REMOVAL (Specify): 7/19/57

22b. DATE THEREOF: 7 | 17 | 57

22c. NAME OF CEMETERY OR CREMATORY: RIVERSIDE

22d. LOCATION (City, town, or county) (State): BERLIN MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: JUL 22 1957

24b. REGISTRAR'S SIGNATURE: Helen Haywards

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 2 should be filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08040 — 08037 — Reg. Dist. No. — 315

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
c. LENGTH OF STAY IN 1b: 33 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 306 Somerset St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Wor
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X2 Ocean City
d. STREET ADDRESS: 306 Somerset St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Gardner — Middle: Willis — Last: Dennis
4. DATE OF DEATH: Month: July — Day: 16 — Year: 1957
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-18-1920
9. AGE (In years last birthday): 36 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Taxi Driver
10b. KIND OF BUSINESS OR INDUSTRY: Transport
11. BIRTHPLACE (State or foreign country): Berlin, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Dennis
14. MOTHER'S MAIDEN NAME: Mary Pitts
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mary Robbins, Mother, Address: 306 Somerset Ocean City Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral-Vascular Accident (Non Traumatic) — INTERVAL BETWEEN ONSET AND DEATH: 30 Minutes
331X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: F J Townsend Jr. M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ — DATE SIGNED: July 16, 57
EXAMINER'S NAME (Type): FRANCIS J. TOWNSEND JR.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7-21-57
22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery
22d. LOCATION (City, town, or county) (State): Berlin Md

23. FUNERAL DIRECTOR'S SIGNATURE: J. F. Stewart Funeral Home, Salisbury, Md — ADDRESS
24a. REC'D BY REGISTRAR: DATE: JUL 19 1957
24b. REGISTRAR'S SIGNATURE: Helen F. Hayward

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08041 08038

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH
a. COUNTY Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MD — b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Whaleyville
d. STREET ADDRESS 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Henry Middle Edward Last Downing
4. DATE OF DEATH Month July Day 6 Year 1957

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Jan. 24, 1915
9. AGE (In years last birthday) 42 yrs.
IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY House Bldg.
11. BIRTHPLACE (State or foreign country) Marionville, Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wilmer Downing
14. MOTHER'S MAIDEN NAME Sarah Fletcher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II
16. SOCIAL SECURITY NO. 217-14-8176
17. INFORMANT Address Mrs. Paul Stepitgensoin Berlin Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 1 hour
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
322.2 Alcoholism
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 6, 1957, to July 6, 1957, that I last saw the deceased alive on July 6, 1957, and that death occurred at 5:00 P.M. from the causes and on the date stated above.
ACTUAL SIGNATURE Robert A. Grubb M.D. ADDRESS (Street, city or town, state) Berlin, Md. DATE SIGNED 7-8-57
PHYSICIAN'S NAME (Type) Robert A. Grubb, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 7/9/57
22c. NAME OF CEMETERY OR CREMATORY Hebron
22d. LOCATION (City, town, or county) Hebron (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage ADDRESS Berlin Md
24a. REC'D BY REGISTRAR DATE JUL 11 1957
24b. REGISTRAR'S SIGNATURE Helen F. Hayward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG218 7-22-57 et

CERTIFICATE OF DEATH

08042

08039

Reg. Dist. No. 310

1. PLACE OF DEATH

COUNTY: WORCESTER — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: RFD #2 Box 310

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: MARYland COUNTY: worcester

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City

STREET ADDRESS (If rural give location): RFD #2 Box 310

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Rose	ANNA	Ewell	July	5	1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	C.	Widowed	Sept. 27 1886	70 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic		Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Handy	Annie Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		219-07-0510	John James Ewell

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

IMMEDIATE CAUSE (A): Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days.

ANTECEDENT CAUSE(S) DUE TO (B): Essential Hypertension — 1 yr.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C):

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (a) Dehydration (b) Exhaustion — 1 wk.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
444X		YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/9/, 1957, to July 4, 1957, that I last saw the deceased alive on July 4, 1957, and that death occurred at 4:A.M, from the causes and on the date stated above.

SIGNATURE	ADDRESS (Street, city, town, state)	DATE SIGNED
Cecil A. Downey M.D.	Pocomoke City, Md.	7/5/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7/8/57	Wattsville Cem.	Wattsville, VA.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
JUL 16 1957	Anne Hute	Edgar Wharton — New Church, VA.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08043

CERTIFICATE OF DEATH

08040 3JJ

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY 21012
d. STREET ADDRESS: 213 DAVIS ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GOLDIE Middle EDITH Last GRIFFIN

4. DATE OF DEATH: Month JULY Day 29 Year 1957

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: DEC. 29, 1884

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): BERLIN MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM HUDSON

14. MOTHER'S MAIDEN NAME: ROSINA McCABE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT: MR. C. H. GRIFFIN, Address: SALISBURY MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Liver & Secondary
156.1
DUE TO (b): Metastasis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cachexia & Dyspnea

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 15, 1957, to July 26, 1957, that I last saw the deceased alive on 26 July, 1957, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Herman A. Robbins M.D. ADDRESS (Street, city or town, state): Berlin, Md. DATE SIGNED

PHYSICIAN'S NAME (Type): HERMAN A. ROBBINS M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/1/1957

22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

22d. LOCATION (City, town, or county): BERLIN (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna H. Burbage ADDRESS: Berlin Md.

24b. REG'D BY REGISTRAR DATE: AUG 5 1957

24b. REGISTRAR'S SIGNATURE: Helen F. Haywood

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08044 — Reg. Dist. No. 08041 351

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH — a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL SNOW HILL
c. LENGTH OF STAY IN 1b: 7 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SNOW HILL x 2
d. STREET ADDRESS: 108 FRANKLIN ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RALPH — Middle LEVIN — Last HALL
4. DATE OF DEATH: Month JULY — Day 3 — Year 1957
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jul 20 - 1944
9. AGE (In years last birthday): 13/4 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SCHOOLBOY
10b. KIND OF BUSINESS OR INDUSTRY: ✓
11. BIRTHPLACE (State or foreign country): VIRGINIA Appalachia
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: HARRY HALL
14. MOTHER'S MAIDEN NAME: Alice Kelly
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: HARRY HALL — Address: SNOW HILL MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ACCIDENTAL DROWNING — INTERVAL BETWEEN ONSET AND DEATH: 15 min
929.8
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): DROWNED WHILE BATHING IN IRRIGATION POND ON A FARM
20c. TIME OF INJURY: Hour 4:45 p.m. — Month, Day, Year: July 3 1957
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): farm
20f. (City or town): Snow hill , (County): Worc (State): Md,

21. I certify that I taak charge of the remains described abave, held an Autapsy ☐, Inspectian ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Hamicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Robert C. La Mar M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 7-4-57
EXAMINER'S NAME (Type): ROBERT C. LA MAR, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 6 57
22c. NAME OF CEMETERY OR CREMATORY: Presbyterian Cemetery
22d. LOCATION (City, town, or county): Snow Hill (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ellery C. Timmis — ADDRESS: Snow Hill, Md
24a. REC'D BY REGISTRAR — DATE: JUL 8 1957
24b. REGISTRAR'S SIGNATURE: Evelyn Cooper

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 6,5,7,8,9 FilmC217 7-11-57 et

08045

08042

Reg. Dist. No. 3N

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b: 81 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2 BERLIN
d. STREET ADDRESS: 10 OCEAN CITY BLVD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First DELLA Middle MAE Last JARMON

4. DATE OF DEATH: Month JULY Day 4 Year 1957

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 29, 1876

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): BERLIN MD RTD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM L. HUDSON

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: No

17. INFORMANT: MR. WILLIAM JARMON Address: BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Complete INTESTINAL Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 1 week

153X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (b): Probable CARCINOMA of COLON — ?

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 578x CHRONIC INTESTINAL HEMORRAGHE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from OCTOBER, 1954 to July 4, 1957, that I last saw the deceased alive on July 4, 1957, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert A. Grubb M.D. ADDRESS (Street, city or town, state): BERLIN, MD. DATE SIGNED: 7-5-57

PHYSICIAN'S NAME (Type): ROBERT A. GRUBB, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 7/7/57

22c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

22d. LOCATION (City, town, or county) (State): BERLIN MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: JUL 9 1957

24b. REGISTRAR'S SIGNATURE: Helen F. Hayward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages [illegible] should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08933 **CERTIFICATE OF DEATH** 08043

Reg. Dist. No. 350

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b: 45 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Front Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 42 Pocomoke City
d. STREET ADDRESS: 1 Front Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Albert; Middle: Hundley; Last: Mariner

4. DATE OF DEATH: Month: July; Day: 7; Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 18, 1880

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Wheelwright and Blacksmith

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Oliver James Mariner

14. MOTHER'S MAIDEN NAME: Amanda Ailsworth

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-16-9688

17. INFORMANT: Address: Jermond Lee Mariner, Pocomoke, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
334X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Hypertension — ?
DUE TO
(c): Cerebral Arterio Sclerosis — 3 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
612X Prostate removed.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April, 1957, to July 7, 1957 that I last saw the deceased alive on July 7th, 1957, and that death occurred at 6 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: N. E. Sartorius Sr. M.D.

ADDRESS (Street, city or town, state) DATE SIGNED

PHYSICIAN'S NAME (Type): N. E. Sartorius Sr. Pocomoke City, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 10, 1957

22c. NAME OF CEMETERY OR CREMATORY: Nelson Cemetery

22d. LOCATION (City, town, or county) (State): Rural Pocomoke City, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson ADDRESS: Pocomoke, Md.

24a. REC'D BY REGISTRAR DATE: 7/12/57

24b. REGISTRAR'S SIGNATURE: Anne Wuste

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The both copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

08044

08046

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 35J

1. PLACE OF DEATH

COUNTY Worcester MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin

LENGTH OF STAY (In this place) 12 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md COUNTY Worcester

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin

STREET ADDRESS (If rural give location) Railway Ave

3. NAME OF DECEASED (Type or Print) (First) Bessie (Middle) (Last) May

4. DATE OF DEATH (Month) July (Day) 24, (Year) 1957

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
F	C	W	February 1883	74 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Domestic	None	Raleigh, N.C	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Moses Jeffries	Nellie Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	None	Esther Braddell — Berlin

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH —

ANTECEDENT CAUSE(S) DUE TO (B) Hypertensive Cardio-vascular Disease — 3½ yrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
4-45		YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-16, 1953, to 7-23, 1957, that I last saw the deceased alive on 7-27, 1957, and that death occurred at 3:15 A.M, from the causes and on the date stated above.

SIGNATURE Leroy H. Seely, Jr. M.D. ADDRESS (Street, city, town, state) Berlin, Md DATE SIGNED 7/24/57

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	7-27-57	Evergreen	Berlin Md

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
DATE AUG 1 1957	Albert F. Hayward	Burton McLeod	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08045

08047

CERTIFICATE OF DEATH

Reg. Dist. No. 550

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin Rural #3 Box 35
c. LENGTH OF STAY IN 1b 48 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin Rural #3 Box 35
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First John Middle Last Parker
4. DATE OF DEATH Month July Day 1 Year 1957
5. SEX Male
6. COLOR OR RACE Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH July 14 1875
9. AGE (If years last birthday) 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) Pittsville Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Charles Parker
14. MOTHER'S MAIDEN NAME Millie Timmons
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (unknown)) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs Mary Parker Address Berlin Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema C Rural #3 Box 35 — INTERVAL BETWEEN ONSET AND DEATH 4 days
DUE TO 4438
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Congestive heart failure — 27 days
DUE TO
(c) Hypertensive Cardio-vascular disease — Several years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 4341
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/16, 1956, to 6/26, 1957, that I last saw the deceased alive on 6/26, 1957, and that death occurred at 2:10 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Henry U. Shockley Jr. M.D. ADDRESS (Street, city or town, state) Berlin Md DATE SIGNED 7/1/57
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF July 4/57
22c. NAME OF CEMETERY OR CREMATORY St Peters Cemetery
22d. LOCATION (City, town, or county) (State) Berlin Rural #3 Box 35 Md
23. FUNERAL DIRECTOR'S SIGNATURE Elmer E. Timmons ADDRESS Snow Hill, Md
24a. REC'D BY REGISTRAR DATE 7/3/57
24b. REGISTRAR'S SIGNATURE Helen Hayward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08045 — 08046 — Reg. Dist. No. 305

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin(Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D.# (Route 376) Libertytown Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 2212 2
d. STREET ADDRESS: 204 Record St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle RAY — Last PARKS

4. DATE OF DEATH: Month JULY — Day 22 nd — Year 19 57

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: August 14,1927
9. AGE (In years last birthday): 29 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Route Salesman(Koester Bakery Co.)
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Tangier Island, Virginia
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Wesley Parks
14. MOTHER'S MAIDEN NAME: Etta Parks

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs.Alberta Ruth Parks(Wife) Address: 204 Record St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock, acute Cer. & Scull & Loss of Brain — INTERVAL BETWEEN ONSET AND DEATH: minutes
823x
DUE TO (b): + Exposure, + Fractured Femur,
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Fx. S.L. Radius & Ulna, Rt Femur, L. Clavicle
Fx. 7-8 Rib Rt., Compression, R side Chest

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Ran into an obstruction on Rt 50 & Md.
20c. TIME OF INJURY: 8 AM a.m. p.m. — Month, Day, Year: 7/22/19 57
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rt. 50 & Highway
20f. (City or town) Berlin (Libertytown) (County) Worcester (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Herman A. Robbins M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 7/22/57
EXAMINER'S NAME (Type): Dr. Herman A. Robbins

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 25,1957
22c. NAME OF CEMETERY OR CREMATORY: Swain Meth. Church Cemetery
22d. LOCATION (City, town, or county) (State): Tangier Island, Virginia

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: HOLLOWAY & COMPANY FUNERAL HOME — SALISBURY, MD.
24a. REC'D BY REGISTRAR DATE: JUL 25 1957
24b. REGISTRAR'S SIGNATURE: Helen F. Haymond

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08049 08048

CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Girdletree
c. LENGTH OF STAY IN 1b: 63 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: /

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Girdletree
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Harvey — Middle W. — Last Redden

4. DATE OF DEATH: Month July — Day 14 — Year 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 13-1894

9. AGE (In years last birthday): 63/4/1 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Girdletree, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George W. Redden

14. MOTHER'S MAIDEN NAME: Ella Lankford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes World War I

16. SOCIAL SECURITY NO.: /

17. INFORMANT — Address: Mrs Rosa H. Redden, Girdletree Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 min

420.1

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (b): Arteriosclerotic Myocarditis — unknown
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

422.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1950, 19____, to 7/14/57, 19____, that I last saw the deceased alive on 7/11/57, 19____, and that death occurred at 5.45 P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE: Paul Cohen M.D.

PHYSICIAN'S NAME (Type): _____

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: July 17 57 — 22c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery — 22d. LOCATION (City, town, or county): Girdletree (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: Mary E. Timmis — ADDRESS: Snow Hill, Md

24a. REC'D BY REGISTRAR DATE: JUL 16 1957 — 24b. REGISTRAR'S SIGNATURE: Elwyn Cooper

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08049 3 JF
Reg. Dist. No.

08050

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Beach At Dorchester St

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Pennsylvania — b. COUNTY: York
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): York . 75 x-3
d. STREET ADDRESS: 1026 W. King
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Russell — Middle: Gerald — Last: Reider
4. DATE OF DEATH: Month: July — Day: 25 — Year: 1957

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb 19, 1908
9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pattern Maker
10b. KIND OF BUSINESS OR INDUSTRY: Manufacturing
11. BIRTHPLACE (State or foreign country): York, Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Reider
14. MOTHER'S MAIDEN NAME: Fanny Shue

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Lylah Reider (wife) Address: 1026 W King York, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion Acute — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes
DUE TO (b): Coronary artery disease — 5 years.
DUE TO (c):

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last: 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year: 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: F. J. Townsend Jr. M.D.
EXAMINER'S NAME (Type): FRANCIS J. TOWNSEND, JR.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: July 25, 57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/27/57
22c. NAME OF CEMETERY OR CREMATORY
22d. LOCATION (City, town, or county): York (State): Pa

23. FUNERAL DIRECTOR'S SIGNATURE: Anna H. Burbage — ADDRESS: Berlin Md
24a. REC'D BY REGISTRAR DATE: JUL 29 1957
24b. REGISTRAR'S SIGNATURE: Helen F. Hayward

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08050

08051

Item 9 FilmG218 7-30-57 et

Reg. Dist. No. 355

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ×2 BERLIN
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BRUCE Middle LEON Last SPENCE

4. DATE OF DEATH: Month JULY Day 19 Year 1957

5. SEX: M

6. COLOR OR RACE: COLORED

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH:

9. AGE (In years last birthday): (78) yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY: DAY WORK

11. BIRTHPLACE (State or foreign country): NEWARK, MD

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JOSEPH SPENCE

14. MOTHER'S MAIDEN NAME: AMANDA COLLINS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: DOLLIE SHOCKLEY Address: BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Shock, due Multiple Fractures — INTERVAL BETWEEN ONSET AND DEATH: Instant

DUE TO (b): + Contusions & F.C.C. Scull + Lac. of Brain

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): F.C.C. Rt Tibia + Fibula, F.S. Rt Clavicle + Internal Injur

813X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Struck by car Truck while riding a bicycle

20c. TIME OF INJURY: 8:30 a. m. — Month, Day, Year: 7/19/1957

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway 113 —

20f. (City or town) (County) (State): Berlin, Worcester Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Herman A Robbins M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): HERMAN A. ROBBINS, M.D.

DATE SIGNED: 7/22/57

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 7/22/57

22c. NAME OF CEMETERY OR CREMATORY: CEDAR CHAPEL

22d. LOCATION (City, town, or county) (State): NEWARK MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage — ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: 7/24/57

24b. REGISTRAR'S SIGNATURE: Helen F. Haywards

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08052 **CERTIFICATE OF DEATH** 08051

Reg. Dist. No. 351

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Newark Md.
c. LENGTH OF STAY IN 1b: 50 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x2. Newark
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Honolulu Middle Long Last Trader

4. DATE OF DEATH: Month July Day 5 Year 1957

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Aug. 22, 1873

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Selbyville, Del.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Zena P. Long

14. MOTHER'S MAIDEN NAME: Patience McCabe

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Maggie I. Trader Address: Jackson Newark Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: ?
420.1
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 7/5, 1957, to 7/5, 1957, that I last saw the deceased alive on 7/5, 1957, and that death occurred at 12 3/4 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas L. Jones, M.D. M.D. ADDRESS (Street, city or town, state): Snowhill, Md. DATE SIGNED: 7/5/57

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: July 7th 1957

22c. NAME OF CEMETERY OR CREMATORY: Bowen

22d. LOCATION (City, town, or county): Newark (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson ADDRESS: Pocomoke City, Md.

24a. REC'D BY REGISTRAR DATE: JUL 8 1957

24b. REGISTRAR'S SIGNATURE: Thomas Cooper

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08053

CERTIFICATE OF DEATH

08052353
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishopville
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: XXX

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishopville
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Walter — Middle: J. — Last: Warren

4. DATE OF DEATH: Month: July — Day: 6 — Year: 1957

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 30 1890

9. AGE (In years last birthday): 67 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Josiah Warren

14. MOTHER'S MAIDEN NAME: Olevia Rayne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): World War # 1

16. SOCIAL SECURITY NO.: 218-20-7377

17. INFORMANT: Clarence Warren — Address: Bishopville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs
443X
DUE TO (b): Hypertension - arteriosclerosis — ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 422.1

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1955, 19__, to 7-6-, 1957, that I last saw the deceased alive on 7-6-57 a.m. 19 57, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank Lewis M.D. — ADDRESS (Street, city or town, state): Pollards Maryland — DATE SIGNED:

PHYSICIAN'S NAME (Type): Frank Lewis M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 7/9/57

22c. NAME OF CEMETERY OR CREMATORY: I I O O F

22d. LOCATION (City, town, or county) (State): Bishopville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Elden Whaley — ADDRESS: Selbyville Del.

24a. REC'D BY REGISTRAR DATE: JUL 10 1957

24b. REGISTRAR'S SIGNATURE: Hilda R. Bagwell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

C8034 **CERTIFICATE OF DEATH** 08053 350

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 506 Laura

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke City, 42
d. STREET ADDRESS: 506 Laura 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George — Middle T. — Last Williams

4. DATE OF DEATH: Month July — Day 20 — Year 1957

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 12, 1905
9. AGE (In years last birthday): 52 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saw Mill
10b. KIND OF BUSINESS OR INDUSTRY: Timber
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John C. Williams
14. MOTHER'S MAIDEN NAME: Martha Downing

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 191-16-9073
17. INFORMANT: Maggie Williams — Address: Stockton, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Pulmonary Edema	1 day
DUE TO	443X	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Congestive Heart Failure	18 mths.
DUE TO (c)	Hypertensive Heart Disease	18 mths.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	502.1 Chronic Bronchitis	

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/1/56, 19__, to 7/20/57, 19__, that I last saw the deceased alive on 7/20/57, 19__, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Neal A. Downey, M.D. — ADDRESS (Street, city or town, state): 501-4th St, Pocomoke — DATE SIGNED: 7/23/57

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 7/24/57
22c. NAME OF CEMETERY OR CREMATORY: Wattsville, Cem.
22d. LOCATION (City, town, or county) (State): Wattsville, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton — ADDRESS: New Church, Va.
24a. REC'D BY REGISTRAR DATE: JUL 26 1957
24b. REGISTRAR'S SIGNATURE: Anne Whitty

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08054 — Reg. Dist. No. 2571

08054

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SNOW HILL
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Worc.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill X2
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle — Last WRIGHT
4. DATE OF DEATH: Month July — Day 19 — Year 57

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 27-1930
9. AGE (In years last birthday): 27-2-22
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Snow Hill Canning Co.
11. BIRTHPLACE (State or foreign country): Md. Snow Hill
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: JAMES WRIGHT
14. MOTHER'S MAIDEN NAME: NANCY POWELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): N O
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 207-20-16a3
17. INFORMANT: Wilsie Townsend — Address: Snow Hill, Md. Rural #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rupture of Heart — INTERVAL BETWEEN ONSET AND DEATH: none

DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 951x
(b) Bullet wound

DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Possibly had been drinking alcoholic beverages
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): X
20c. TIME OF INJURY: Hour — o. m. / p. m. — Month, Day, Year — 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE: Robert C. LaMar M.D.
EXAMINER'S NAME (Type): ROBERT C. LA MAR, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 7-20-57

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: July 23/57
22c. NAME OF CEMETERY OR CREMATORY: M.t Wesley
22d. LOCATION (City, town, or county) (State): Snow Hill, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Clay E. Timmons
ADDRESS: Snow Hill, Md
24a. REC'D BY REGISTRAR DATE: JUL 23 1957
24b. REGISTRAR'S SIGNATURE: Edwyn Cooper

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55